General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Canna Pharmacy, 27 Wyndham Crescent, CARDIFF, CF11 9EE

Pharmacy reference: 1114605

Type of pharmacy: Community

Date of inspection: 14/11/2024

Pharmacy context

This pharmacy is inside a medical centre in an inner-city district of Cardiff. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and a seasonal influenza vaccination service for NHS patients. Substance misuse services are also available.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures to help make sure the team works safely. Its team members record and review their mistakes so they can learn from them. And they take action to help reduce the risk of similar mistakes happening again. The pharmacy keeps the records it needs to by law. But details are missing from some of the records, so it may not always be able to show exactly what has happened if any problems arise. Pharmacy team members keep people's private information safe. And they understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including the recording of dispensing errors and near misses. Only one record of a dispensing error was available to view, but the pharmacist said that no other errors had been made. He explained that he discussed near misses with relevant team members at the time they came to light. And that any patterns or trends that emerged were discussed with the whole team. Action had been taken to reduce risks that had been identified. For example, following some near misses, different forms of ramipril and different strengths of risperidone and propranolol had been distinctly separated on dispensary shelving. Shelf edge stickers had also been used to highlight these products to the pharmacy team to help reduce the risk of selection errors.

A range of paper standard operating procedures (SOPs) underpinned the services provided. Most members of the pharmacy team had signed training records to confirm that they had read and understood these. The newest member of the pharmacy team was in the process of reading and signing SOPs relevant to her role. Team members were able to describe their roles and responsibilities when questioned and correctly described the activities that could not take place in the absence of the responsible pharmacist.

Evidence of current professional indemnity insurance was available. Pharmacy records were up to date, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed medicines and controlled drugs records. However, there were occasions on which the pharmacist had not signed out of the RP register to show the time at which they had relinquished responsibility for the safe and effective running of the pharmacy. So, there was a risk that it would not be possible to identify the pharmacist in charge if something went wrong. Most CD running balances were checked at the time of dispensing, or monthly. Methadone balances were checked regularly. However, some CDs which were not frequently supplied had not been subject to a balance check for several months, which increased the risk that concerns such as dispensing errors or diversion might be missed.

The pharmacist had undertaken advanced formal safeguarding training. Other team members had undertaken basic formal safeguarding training. All team members had access to guidance and local safeguarding contact details via the internet. A notice in the consultation room advised people to ask a member of the team for help if they wanted to have a chaperone present.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The superintendent pharmacist worked at the pharmacy on most days. His absences were covered by regular locum pharmacists. The pharmacy team consisted of three dispensing assistants (DA), a trainee DA and a trainee medicines counter assistant, who also worked as a delivery driver for the pharmacy every Tuesday. A pharmacy technician who was employed as an accuracy checker was on long-term leave of absence. The pharmacist explained that he was currently recruiting for another member of staff to cover her hours. The staffing level appeared adequate to manage the pharmacy's workload. There were no specific targets or incentives set for the services provided.

Members of the pharmacy team working on the medicines counter were observed using appropriate questions when selling over-the-counter medicines to people. And they referred to the pharmacist on several occasions for further advice on how to deal with transactions.

Pharmacy team members had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They explained that much of their learning was via informal discussions with the pharmacist. They had also completed mandatory training provided by NHS Wales on mental health awareness and improving the quality of services provided. However, the pharmacy team did not have a structured training programme, which meant that individuals might not keep up to date with current pharmacy practice. There was no formal appraisal system in place, which meant that development needs might not always be identified or addressed. But all team members could informally discuss performance and development issues with the pharmacist whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and well-organised. It has enough space to allow for safe working. There is a room where people can have conversations with team members in private.

Inspector's evidence

The pharmacy was clean, tidy and well-organised. It was small, but there was enough space to allow for safe working. Some dispensed medicines awaiting collection were being temporarily stored on the floor, but they did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use.

A consultation room was available for private consultations and counselling and this was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are mostly easy for people to access. Its working practices are generally safe and effective. It largely stores its medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy team offered a range of services, which were appropriately advertised. There was wheelchair access into the pharmacy but access into the consultation room was impeded by a table that partially blocked the entrance door. The pharmacist explained that he could provide services to people who could not access the consultation room in the main retail area outside pharmacy hours, or during the lunch hour when the pharmacy was closed. He was also able to use one of the surgery's treatment rooms to provide services if necessary. The pharmacy had an internet-based telephone system with multiple handsets that allowed two people to make calls to its number at the same time. This meant that people had good access to the pharmacy team by phone. Pharmacy team members said that they would signpost people requesting services they could not provide to other nearby pharmacies. Some health promotional material was on display in the retail area. The pharmacy team spoke several languages between them and explained that this benefited many people from the local community whose first language was not English.

The pharmacy team used baskets to help ensure that medicines did not get mixed up during the dispensing process. Dispensing labels were initialled by the dispenser and accuracy checker to provide an audit trail. Prescription forms were not always retained for dispensed items awaiting collection, except for prescriptions for controlled drugs requiring safe custody. This meant that prescriptions for some schedule 3 CDs might not be marked with the date of supply at the time the supply was made, as required by legislation. Most prescriptions were scanned, and the image remained available for reference. However, this was not the case for all prescriptions. There was a risk that an accurate and complete record of prescription details might not be available for reference at the time of supply.

Stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item needed to be added. A member of the dispensing team explained that stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. This practice helped ensure that assembled prescriptions were checked for validity before handout to the patient.

Prescriptions for high-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted, so there was a risk that counselling opportunities could be missed. The pharmacist explained that local surgery teams annotated prescriptions for methotrexate and lithium with the date on which the person's next blood test was due. And new or walk-in patients were asked for relevant information about blood tests and dosage changes. But this information was not recorded, which might lead to a lack of continuity of care. Pharmacy team members were aware of the risks of valproate and topiramate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs. The pharmacy did not have any people prescribed valproate or topiramate who met the risk criteria. However, the pharmacist confirmed that any such patients would routinely be counselled and provided with information that was available in the retail area.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. Compliance packs were labelled with descriptions of the medicines they contained so that individual medicines could be easily identified. Patient information leaflets were routinely supplied. A list of people who received their medicines in compliance packs was displayed in the dispensary for reference. Each patient had a clear plastic wallet that contained their personal and medication details and any current prescriptions.

The pharmacy provided a discharge medicines review service and uptake of this was steady. There was a high uptake of the common ailments service. The pharmacist was an independent prescriber and was able to provide the extended common ailments service to treat UTIs, and minor skin and ear infections. The pharmacy offered a sore throat test and treat service and uptake of this was also high. Demand for the emergency supply of prescribed medicines service was low, as the pharmacy was situated inside the local surgery, which had similar opening hours, so people were usually able to obtain a valid prescription from a GP in an emergency. The pharmacy offered an EHC (emergency hormonal contraception) and bridging contraception service and an influenza vaccination service for NHS patients. It also provided a blood pressure measurement service for a small charge.

The pharmacy provided a prescription collection service from five local surgeries. It also offered a medicines delivery service on one day each week for a charge. The delivery driver used a delivery sheet to record each delivery that was made. Patients or their representatives signed to show if they had received a controlled drug as an audit trail. In the event of a missed delivery, the delivery driver put a notification card though the door and brought the prescription back to the pharmacy.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Medicines requiring cold storage were kept in a large medical fridge. Maximum and minimum temperatures for the fridge were checked and recorded daily and the records showed that temperatures were consistently within the required range. CDs were stored in a well-organised CD cabinet. Some higher risk medicines were not stored securely, but this issue was rectified as soon as it was identified. Obsolete CDs were kept separately from usable stock.

Medicines stock was subject to regular documented expiry date checks and date-expired medicines were disposed of appropriately. The pharmacy received safety alerts and recalls via email. The pharmacy team described how they would deal with a medicine recall by contacting patients where necessary, quarantining affected stock, and returning it to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services they offer. And they use equipment in a way that protects people’s privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Separate measures were used for methadone to prevent cross-contamination. Triangles and a capsule counter were used to count loose tablets and capsules. A separate triangle was available for use with cytotoxics. Members of the pharmacy team had access to personal protective equipment such as disposable gloves. The pharmacy had a range of up-to-date reference sources. All equipment was clean and in good working order.

Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the consultation room was used for private conversations and counselling. Computer screens were not visible to people using the pharmacy.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.